United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 16, 2020

COP 2020 Planning Level Letter | PART 2

INFORMATION MEMO FOR AMBASSADOR LANA MARKS, SOUTH AFRICA

FROM: S/GAC – Angeli Achrekar and Maureen Ahmed

SUBJECT: Fiscal Year (FY) 2020 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly POARTS and from Headquarters Country Accountability and Support Teams (CAST), we have thoroughly reviewed progress of the program in your country over time and specifically the end of year results of the Country Operational Plan (COP) 2018 and current COP 2019 implementation as we plan for COP 2020. We have noted the following key successes and specific areas of concern:

Key Successes:

- Improved linkage and resolution of the significant client retention issue that existed at end of FY18, thanks to the intensive quantity and quality of site-level monitoring and corrective action by the PEPFAR team and partners has been commendable.
- Improvements across the prevention portfolio, particularly through VMMC for young men and accelerated PrEP among adolescent girls and young women.
- Increased engagement from both PEPFAR headquarters and field teams and strengthened coordination at all levels to achieve impact between PEPFAR, the Government of South Africa (GoSA), and civil society organizations.

Areas of Concern:

- Underperformance across the treatment clinical cascade persists, threatening the ability to reach the GoSA's goal of achieving epidemic control of HIV/AIDS by reaching and maintaining at least 6.1 million people on treatment by the end of 2020. The PEPFAR South Africa program is not on track to achieving COP 2019 treatment targets across the full cascade. Initiation and retention for men and adolescents lags behind and there is a need for optimized testing as there is significant over-testing and very low index testing. Critically, we still need ~296,000 TX_NET_NEW per quarter in order to reach COP19 targets for epidemic control by the end of 2020 with at least 6.1 million people on treatment in the public sector. With the end of the two-year surge of the additional $500 million USD through COP 18 and 19, we must ensure appropriate transition to the GoSA and adequate USG support to maintain those on treatment.
- Refinements are needed in the prevention portfolio. The VMMC program must improve its impact with age-banding and shift immediately out of <15 year olds. Further

expansion of PrEP and dramatic expansion in the reach and improvement in performance of DREAMS to address the continued new infections in adolescents and young women is required.

- Despite extensive collaboration with and Circular dissemination by the GoSA, bottlenecks and inadequate policy implementation for optimal client-centered services persist at the provincial, district and site levels. Improved GoSA engagement in the HIV response is required, including innovative solutions. Furthermore, in support of efficiency and effectiveness of the PEPFAR program overall, there are opportunities presented with performance and the dramatic increase in DREAMS, PrEP and other areas to begin to align agency strengths to improve maximum impact and reduce inefficiencies.

SECTION 1: COP 2020 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total COP 2020 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

TABLE 1 : All COP 2020 Funding by Fiscal Year

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
Total New Funding	**$ 452,262,170**	**$ -**	**$ -**			**$ 452,262,170**
GHP- State	$ 398,812,170	$ -	$ -			**$ 398,812,170**
GHP- USAID	$ 50,000,000	$ -	$ -			**$ 50,000,000**
GAP	$ 3,450,000	$ -	$ -			**$ 3,450,000**
Total Applied Pipeline				**$ 50,942,988**	**$ 20,234,842**	**$ 71,177,830**
DOD				$ 100,689	$ -	**$ 100,689**
HHS/CDC				$ 43,902,467	$ 17,235,342	**$ 61,137,809**
HHS/HRSA				$ -	$ -	**$ -**
PC				$ 656,979	$ -	**$ 656,979**
State				$ -	$ -	**$ -**
USAID				$ 6,282,853	$ 2,999,500	**$ 9,282,353**
TOTAL FUNDING	**$ 452,262,170**	**$ -**	**$ -**	**$ 50,942,988**	**$ 20,234,842**	**$ 523,440,000**

***Based on agency reported available pipeline from EOFY 2019.*

SECTION 2: COP 2020 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $316,000,000 ($281,500,000 to sustain gains in treatment services and $34,500,000 for continued support to TB/HIV) and the full Orphans and Vulnerable Children (OVC) level of $104,500,000 ($28,000,000 for continued OVC services and $76,500,000 for vulnerable girls less than 20 years old as part of the DREAMS program) from Part 1 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2 : COP 2020 Earmarks by Fiscal Year *

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	$ 260,000,000	$ -	$ -	$ 260,000,000
OVC	$ 71,600,000	$ -	$ -	$ 71,600,000
GBV	$ 4,603,226	$ -	$ -	$ 4,603,226
Water	$ 1,500,000	$ -	$ -	$ 1,500,000

** Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. These earmark controls above represent the minimum amounts that must be programmed in the given appropriation year. For countries with GHP-State and GHP-USAID funds the C&T and OVC earmark requirements can be met with funding from any combination of the two accounts.*

TABLE 3 : All COP 2020 Initiative Controls

	COP 20 Total
Total Funding	$ 154,500,000
VMMC	$ 36,500,000
Cervical Cancer	$ -
DREAMS	$ 90,000,000
HBCU Tx	$ -
COP 19 Performance	$ -
HKID Requirement	$ 28,000,000

TABLE 4 : Acceleration 20 Applied Pipeline

	COP 20
Total	$ -

***See Appendix 1 for detailed budgetary requirements and other budgetary considerations.*

TABLE 5: New Funding Detailed Initiative Controls

	COP 2020 Planning Level			
	FY20			COP 20 Total
	GHP-State	GHP-USAID	GAP	
Total New Funding	$ 398,812,170	$ 50,000,000	$ 3,450,000	$ 452,262,170
Core Funding	$ 370,812,170	$ 50,000,000	$ 3,450,000	$ 424,262,170
COP19 Performance	$ -			$ -
HKID Requirement ++	$ 28,000,000			$ 28,000,000

++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia

SECTION 3: PAST PERFORMANCE – COP 2018 / FY 2019 Review

Table 4. COP OU Level FY19 Program Results (COP18) and FY20 Targets (COP19)

Indicator	FY19 Result (COP18)	FY20 Target (COP19)
TX Current Adults	3,590,921	4,732,954
TX Current Peds	109,244	143,995
VMMC among males 15 years or older	289,875	416,723
PrEP NEW	30,599	70,621
DREAMS (AGYW completing at least the primary package)	89,157 (75.6% of total AGYW reached)	N/A
TB Preventive Therapy	193,536	738,299

Table 5. COP 2018 | FY 2019 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP/ROP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
DOD	$983,522	$327,390	$656,132
HHS/CDC	$273,311,645	$251,099,494	$22,212,151
PC	$2,375,000	$1,840,560	$534,440
State	$3,111,034	$2,716,171	$394,863
State/AF	$1,689,221	$1,781,890	$(92,669)
USAID	$293,787,970	$258,775,744	$35,012,226
CDC Central	$54,125,785	$3,017,143	$51,108,642
USAID Central	$57,454,299	$56,777,245	$677,054
Grand Total	**$686,838,476**	**$576,355,636**	**$110,502,840**

Table 6. COP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget

Mech ID	Prime Partner	Funding Agency	COP18/FY19 Budget	Actual FY19 Outlays ($)	110% or Over FY19 Outlays (Actual $ - Total COP18 Budget $)
17512	World Health Organization	HHS/CDC	69,768	130,420	(60,652)
13558	Human Science Research Council of South Africa	HHS/CDC	24,057	159,623	(135,566)
70296	FHI 360	USAID	2,936,266	3,222,532	(286,266)
14667	Administrators of the Tulane Educational Fund, The	USAID	750,000	824,154	(74,154)
70288	KHETHIMPILO AIDS FREE LIVING	USAID	16,150,619	18,435,011	(2,284,392)
17536	FHI 360	USAID	288,000	506,741	(218,741)
80005	John Hopkins University	USAID	50,000	91,141	(41,141)

17801	University of North Carolina at Chapel Hill, Carolina Population Center	USAID	600,000	1,329,668	(729,668)

*This snapshot shows partner-level over outlays of 110% or higher. Note that mechanism budgets reflect what was recorded in FACTS Info Legacy, and may not entirely reflect the inclusion of central (i.e. kickstart and surge) funds.

Table 7. COP 2018 | FY 2019 Results & Expenditures

Agency	Indicator	FY19 Target	FY19 Result	% Achievement	Program Classification	FY19 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	4,775,001	4,869,650	102%	HTS Program Area	$33,873,604	98.2%
	HTS_TST_POS	458,921	313,458	68.3%			
	TX_NEW	426,251	251,448	59%	C&T Program Area	$103,180,854	73.3%
	TX_CURR	1,928,861	1,486,670	77.1%			
	VMMC_CIRC	291,601	313,983	107.7%	VMMC Subprogram of PREV	$39,878,254	97.4%
Peace Corps	OVC_SERV	1,585	1,109	70%	OVC Major Beneficiary	76,071	100%
State/AF	HTS_TST	N/A	62,817	N/A	HTS Program Area	$178,482	91.7%
	HTS_TST_POS	N/A	5,688	N/A			
	TX_NEW	N/A	N/A	N/A	C&T Program Area	$87,195	45.7%
	TX_CURR	N/A	N/A	N/A			
	OVC_SERV	N/A	5,593	N/A	OVC Major Beneficiary	$13,469	45.8%
USAID	HTS_TST	6,184,055	8,116,570	132.1%	HTS Program Area	$22,268,086	99.3%
	HTS_TST_POS	604,858	441,787	73.0%			
	TX_NEW	588,661	386,058	65.1%	C&T Program Area	$152,844,725	80.1%
	TX_CURR	2,624,185	2,214,878	84.4%			
	VMMC_CIRC	204,193	185,826	91%	VMMC Subprogram of PREV	$24,645,364	100%
	OVC_SERV	626,556	672,542	107.3%	OVC Major Beneficiary	$23,309,892	96.8%
				Above Site Programs		$62,490,723	N/A
				Program Management		$89,113,561	N/A

COP 2018 | FY 2019 Analysis of Performance

Case Finding

Analysis of case finding results in COP18 reveals a need for improvement in optimized testing. While the program achieved 760,652 HTS_TST_POS, this was 72% of its 1,063,779 target and did so by significantly over-testing with HTS_TST at 13,043,769, 119% of its target of 10,919,056. Index Testing remains extremely low across districts, and only 10% of all

HTS_TST_POS came from index. Rapid scale up of index testing remains a main challenge. Conversely, over 73% of HTS_TST_POS came from Other PITC with yields as low as 5%. Optimize case finding through focused PITC is needed to improve facility testing coverage and yield. To improve case finding, 30% of newly identified PLHIV should be reached through the index testing modality. For children, need to rapidly scale up testing (<15) to ≥15% HTS_TST from index and ≥30%-50% TST_POS from index.

Care and Treatment

Analysis of COP18 performance for Care and Treatment reveals some improvements, but still major gaps across the cascade exist across the portfolio and particularly in the high burden districts. The significant client retention issue that existed at end of FY18 was resolved in FY19, though retention continues to be a problem. Overall, COP18, with the full implementation of the first year of the two-year surge monies, saw the highest TX_NEW and NET_NEW results in the PEPFAR South Africa program. As a whole, PEPFAR South Africa put 636,253 new patients on treatment, reaching a total of 3,700,167 patients overall in the 27 highest burden districts and 4,719,473 across the whole country. In COP 18, TX_CURR Growth increased from 5% in FY18 to 16% in FY19 overall in the 27 districts and ranged from 8-28% in the 27 high burden districts. Linkage increased slightly from 81% in FY18 to 84% in FY19, but is still not where it should be, at 95% across all age, sex, and risk groups.

While linkage and retention improved in FY19, as a result of intense monitoring, commitment from the South African National Department of Health (NDoH), and approximately over 3,000 site visits, the program only reached 81% of COP18 TX_CURR target in the 27 districts. ART initiation and retention, especially for men and adolescents lags behind. For example, between FY18Q4 and FY19Q4, the percentage of males 15+ years on treatment in PEPFAR South Africa decreased by 15%. In FY19, the greatest percentage increase in men on treatment (19%) was found in the 45-49 year-old age band with fewer men being put on treatment in the 25-29 and 30-34 year-old age bands. In addition, in the first three quarters of FY19, the program put less than half the number of men than women on treatment ages 15+ years, and 70% fewer males than females on treatment 25-34 years old. Overall, the program will need to achieve approximately 296,000 TX_NET_NEW per quarter in order to reach COP19 targets by September 30, 2020.

Performance by geographic area and by partner varies. For example, in City of Johannesburg, high burden Siyenza sites experienced significant decreases in early and late missed appointments and loss to follow up (LTFU). Anova increased HTS_POS results by 34% and TX_NEW results by 54% from FY19 Q1 to FY19 Q4. Viral load coverage improved from 13% in FY17 to 81% in FY19. In Tshwane, WRHI experienced a treatment growth of 15.6% between FY19 Q1 to FY19 Q4. Proxy linkage, same day ART initiation, and weekly number of HIV cases identified are all steadily increasing in the district. In Ekurhuleni, Aurum achieved 42% of its TX_NEW target and 66% of its TX_CURR target. In eThekwini, HST achieved 101% of its TX_NEW target and MatCH achieved 88%. In FY19 Q4, MatCH had a TX_NET_NEW of negative 4,698 in eThekwini.

To this end, Anova in City of Johannesburg and WRHI in Tshwane must optimize case finding and strengthen retention to ensure solid trajectory towards COP19 treatment goals. Aurum must be placed on a Performance Improvement Plan (PIP) in Ekurhuleni and show improvement at

planning meetings with COP19 Q1 data. If performance does not improve by end of COP19 Q2, partner remediation and/or transition plans must be in effect immediately. MatCH must be placed on a PIP in eThekwini and show improvement at planning meetings with COP19 Q1 data. If performance does not improve by end of COP19 Q2, recommendation for rationalization in eThekwini for more efficient and effective programming and full partner transition from poorer performing partner (MatCH) to better performing partner (HST) in eThekwini.

Voluntary Medical Male Circumcision (VMMC)

Analysis of the VMMC results in COP 18 reveal some key achievements, but also some important gaps. The program achieved 513,631 VMMC_CIRC, 101% of its FY19 goal. CDC achieved 108% of its FY19 target, USAID achieved 91%. However, effective age-banding for VMMC is critical in order to ensure maximal impact. The program reached 62,287 beneficiaries for over 30 age band, 227,588 for 15-24 age band, and 225,541 for the under <15 age band. Approximately 43% of VMMCs are occurring in the least impactful <15 age band to interrupt HIV transmission.

Pre-Exposure Prophylaxis (PrEP)

Analysis of the PrEP program reveals significant achievement. PrEP_New achievement in FY 2019 was 30,599. The program achieved a 2,198% increase in AGYW PrEP_NEW from FY18 Q4 to FY19 Q4, and a 375% increase in KP PrEP_New from FY18 Q4 to FY19 Q4. The program is doing extremely well in reaching, and exceeding PrEP target for the 20-24 AGYW cohort. The program is reaching PrEP targets for AGYW 15-24 in DREAMS districts.

DREAMS

Reductions of new infections among adolescent girls and young women is absolutely critical in South Africa. The South Africa program reached approximately only 115,000 active DREAMS beneficiaries during FY19 with a current budget of $33 million. The program is not reaching enough beneficiaries commensurate for this level of investment. The program is struggling with the 20-24 cohort, as only 36% were reached with the full primary package of services. A number of AGYW, across all age bands, have not completed the primary package even after being in DREAMS 25+ months. There is a large proportion of AGYW who have completed the primary package but have only been in DREAMS for 6 months or less.

Orphans and Vulnerable Children (OVC)

The OVC_HIVSTAT known status proxy for FY19 in South Africa was 85%. All OVC implementing partners must ensure that 90% or more of OVC beneficiaries under age 18 have a known HIV status or are deemed not to need a test based on a standard HIV risk assessment.

SECTION 4: COP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements in place no later than the beginning of COP 2019

implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs.

For COP 2020, the failure to meet any of these requirements will result in reductions to the South Africa budget. (See Section 2.2. of COP Guidance)

Table 8. COP 2020 (FY 2021) Minimum Program Requirements

	Minimum Program Requirement	Status	Outstanding Issues Hindering Implementation
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Test and Start was rolled out in 2016. National ART Guidelines stipulate that patients should initiate ART within 7 days including on the day of diagnosis when possible. In PEPFAR Phuthuma sites, Same Day ART initiations are at 80% with proxy linkage exceeding 95% for most within the last 6 months.	Linkage is lower in non-PEPFAR Phuthuma sites. Overall proxy linkage for FY19 was 84% nationally at PEPFAR-supported sites. Challenges still exist with ensuring those who aren't initially eligible for treatment are rapidly and continuously engaged and in ensuring those identified in the community are linked to treatment. The program must ensure 95% linkage for all clients across all age, sex, and risk groups. .
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for	The GoSA is transitioning the majority of adult first line patients to TLD. The South Africa National Health Council approved a TEE to TLD transition plan in October 2019. Updated ART guidelines were signed by the acting DG in November 2019, and guidelines were distributed that same month. TLD was	October 2019 is already delayed and beyond the original planned dates to roll out TLD. The commodity projections show that South Africa will now fully transition to TLD late by June 2022. The country must find a way to expedite TLD transition, particularly in the highest burden PSNUs.

[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

	children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	officially launched in KZN on November 27, 2019. Nevirapine has been removed for all patients except for children <4 weeks.	Additionally, PEPFAR must continue discussions with NDoH regarding the potential to decant stable patients on TLD to CCMDD after a single suppressed VL.
	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	In South Africa, two months multi-month dispensing (MMD) is the standard NDoH policy as per the National Adherence Strategy. Recent revisions include working towards 3 MMD. While the NDoH Steering Committee has approved a 6 MMD prescription for stable patients, the GoSA has expressed multiple concerns. Discussions are currently underway with NDoH on a proposed phased implementation of 6 MMD.	Factors affecting the introduction of 3, 6, or 12-month MMD include: 90 and 180 count pack sizes of TLD are not on the SA government ARV contract; 180 count packs are not registered in South Africa; changes required in CCMDD tender with the GoSA; and implementation of 3-6 MMD would require an upfront investment in additional commodities for buffer stock. In COP19, the country must immediately scale up to 3 MMD using bundled 30 count packs and swiftly move to 6 MMD as soon as possible.
	4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20; cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	South Africa provides IPT for 12 months in adult ART patients (15 years and above). This will change with 3HP introduction, slated to begin April 2020. Revised TPT guidelines (which will include a 3HP roll out plan and additional regimens proposed in line with WHO guidelines on treatment of LTBI) should be approved by January 2020.	Despite TPT availability in all PEPFAR supported districts, initiation and completion is still below target in some PSNUs. While 19 districts showed improved TPT completion performance from FY19 Q2 to Q4, the overall FY19 APR TPT completion rate was sub-optimal (58%). The program must continue to work with NDoH to increase TPT coverage and

[2] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019
[3] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016
[4] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World

Health Organization, 2018

			finalize the adherence model and package for patients on TPT, as well as develop a TPT module for Tier.net.
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	The program saw an increase in viral load coverage from FY19 Q1 (69%) to FY19 Q4 (76%) across PEPFAR and centrally supported sites.	NHLS has sufficient laboratory capacity for project VL specimen volumes for FY2020, however gaps remain in reaching the required VL coverage rates at facility level. Activities to improve coverage are being implemented in COP19 activities and should continue in COP20.
Case Finding	6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	The GoSA has prioritized and is supporting full implementation of index testing for sexual partners and children of PLHIV. HIV self-screening is also being scaled up and fully supported. Both these modalities are now included in the revised National HTS register. The NDoH index testing guidance includes specific procedures to ensure consent, protect confidentiality and prevent	Index testing contribution to HTS_TST_POS is extremely low. In COP19, rapidly scale up index testing for all populations, including for children (<15) to greater than or equal to 30% -50% TST_POS from index.

[5] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/

		harm related to intimate partner violence, informed by broad consultations. PEPFAR and NDoH are working together to ensure structures are in place to support consent, disclosure to spouse and sexual partners, and to manage risks and incidence of intimate partner violence related to HIV disclosure. Pediatric case finding modalities prioritize improved PICT, including through case managers, and index case testing. Adolescent case finding is optimized through youth friendly services and 'Youth Zones' in facilities.	

revention and OVC	7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men	Analysis of the PrEP program reveals significant achievement in FY19. Immediate PEPFAR priorities in COP19 include: ensuring support for NDoH PrEP scale-up by increasing PEPFAR interagency PrEP_NEW targets, to be implemented as part of a comprehensive package of prevention services. The priority will be on layering and offering PrEP as part of Combination Prevention in keeping AGYW HIV negative.	For successful PrEP scale-up, PEPFAR should prioritize strengthening adherence and continuation/retention in COP19 and COP20.
	engaged in high-risk sex practices)[6]		

	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	Through effective case management, household visits, and improved use of data and targeting, OVC implementing partners identify the most vulnerable children (including AGYW, children and adolescents living with HIV) and provide 1:1 support that empowers OVC to stay in and progress in school; access health services and grants; reduce violence and abuse; prevent HIV infection; and be adherent and retained in HIV care services.	No outstanding barriers, continue to implement per COP19.
Policy & Public Health Systems Support	9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB,	South Africa prohibits, through legislation, informal and formal user fees for HIV, TB, antenatal care and all primary level care in the public sector. PEPFAR SA continues to work at the national, provincial, and district levels to ensure that this	Instances of non-compliance with user fee policies should continue to be reported by PEPFAR to national-level counterparts for remediation.

[6] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

	cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	policy is implemented in facilities and that all people have access to HIV services.	
	10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	PEPFAR Siyenza, which was implemented at 419 facilities in FY19, conducted weekly site visits by PEPFAR, DSP, and DoH staff. Standardized tools and site-level data collection were institutionalized to identify poor performance and immediately address issues. Two MoH endorsed Circulars were disseminated to support these efforts. NDoH launched 'Operation Phuthuma' in FY19, which prioritized 756 facilities then expanded nationally. The effort focuses on quality improvements at all levels. Phuthuma conducts weekly facility and sub-district meetings, as well as monthly district meetings and provincial Nerve Centers in all provinces.	Despite extensive collaboration with and Circular dissemination by the GoSA, bottlenecks and inadequate policy implementation for optimal client-centered services persist at the provincial, district and site levels. Improved GoSA engagement in the HIV response is required, including innovative solutions.
	11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host	The country has implemented a national strategy to improve linkage and retention at all sites. PEPFAR South Africa is working with NDoH to align U=U campaign with the GoSA's Welcome Back campaign.	All PEPFAR supported provinces should approve the U=U campaign to promote completion of treatment adherence, VL tests, and youth-friendly treatment literacy.

[7] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

[8] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

	country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.		
	12. Clear evidence of agency progress toward local, indigenous partner prime funding.	The program exceeds the 2020 PEPFAR 70% target, with 78% of funding to indigenous partners in COP19, an increase from 76% in COP18. PEPFAR South Africa adheres to the COP19 specific guidance with the majority of prime partners (47 of 77) being local indigenous.	No outstanding barriers.
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	There is clear commitment by the GoSA to continuously increase budgetary support towards the HIV response. The recent GoSA budget allocation for HIV indicates a continued increase from $1.7 billion in 2018/2019, to $2.1 billion in 2020/2021, accounting for over 70% of the country's HIV expenditure. The U.S. government committed to only a two-year surge of approximately $500 million in COP 18 and COP 19.	The GoSA should continue to invest domestic resources maximize HIV-related health outcomes at the national, provincial, and districts and ultimately to sustain the HIV response.

	14. Monitoring and reporting of morbidity and mortality	South Africa's national morbidity and mortality reporting system is supported by a range of	PEPFAR South Africa should continue supporting expansion of effective national HIV data reporting
	outcomes including infectious and non-infectious morbidity.	data sources and institutions, including the District Health Information System, Birth and Death Registries, Census and cause-specific data reporting systems. Current GoSA investments include capacity development to improve the completeness and accuracy of existing data systems and to strengthen reconciliation and triangulation of data from various sources and at all levels.	systems including Provincial Information Hubs and implementation of the HPRS infrastructure support at the facility level.
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	South Africa's Health Patient Registration System (HPRS) is deployed in 75.45% of NDoH-supported health facilities. 43.1 million (73.3% of the total population) individuals have been registered.	Use of HPRS remains inconsistent and suboptimal. A large number of infrastructural, capacity, and system integration barriers often render HPRS nonfunctional and cannot be addressed by DSPs at facility or district level.

In addition to meeting the minimum requirements outlined above, it is expected that South Africa will:

Table 9. COP 2020 (FY 2021) Technical Directives

OU –Specific Directives
HIV Clinical Cascade
1. Treatment: Ensure 95% patient retention at all PEPFAR-supported sites. Continue with targeted U=U campaign and Welcome Back campaigns. Institutionalize the function of Linkage Officers and Case Managers for retention in care. Roll out best linkage and retention practices from high performing DSPs to all DSPs. Propose bold priorities and innovations, tailored to populations that are missed to close the treatment gap and ensure clients are linked and retained on treatment. With the end of the 2-year surge of the additional $500 million USD through COP 18 and 19, we must ensure appropriate transition to the GoSA and adequate USG support to maintain those on treatment.

2. Aurum must be placed on a Performance Improvement Plan (PIP) in Ekurhuleni now and show improvement at planning meetings with COP19 Q1 data. If performance does not improve by end of COP19 Q2, partner remediation and/or transition plans must be in effect
immediately and realized for COP 20. MatCH must be placed on a PIP in eThekwini now and show improvement at planning meetings with COP19 Q1 data. If performance does not improve by end of COP19 Q2, recommendation for rationalization in eThekwini for more efficient and effective programming and full partner transition from poorer performing partner (MatCH) to better performing partner (HST) in eThekwini for COP 20.
3. Reaching Men: Focus on adding men to treatment, specifically within the 25-34 year age band, and attain viral suppression among this group. Leveraging the insights garnered through MenStar, and as a priority MenStar country, PEPFAR South Africa should implement a core package of services that meet men where they are with what they need. Please see the newly released MenStar Guidance Document and Compendium for recommend strategies, interventions, and examples.
4. Rapidly roll out the U=U campaign to promote the urgency of treatment adherence and completion of viral load tests.
HIV Prevention
1. The VMMC program must achieve 80% saturation among clients 15-24 in priority districts and must immediately pivot out of <15 age bands. Strengthen VMMC program through quality assurance, continuous quality improvement and data quality assessments.
2. DREAMS must accelerate programming to achieve 100% saturation in existing DREAMS districts. Expedite the implementation of the South Africa database to accurately track layering across all DREAMS partners. With the dramatic increase in DREAMS investment in COP20, DREAMS must also expand significantly and reach high incidence districts. A DREAMS Coordinator (and other staffing needs) within the PCO should also be hired or provincially. Connect older DREAMS and other AGYW (20-24 year olds) to job readiness, income-generating and employment opportunities tied directly to program implementation, particularly at provincial levels. Specific guidance can be found below on significant expansion of DREAMS.
3. PrEP is doing extremely well in reaching, and exceeding PrEP target for the 20-24 AGYW cohort. The program is reaching PrEP targets for AGYW 15-24 in DREAMS districts. This effort should be expanded.
4. OVC partners must work together to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC SNUs are offered the opportunity to enroll in the comprehensive OVC program. Increase the proportion of OVC with known HIV status to greater than or equal to 95%. Scale up interventions to reduce the high rate of sexual violence among 9-14 year olds.
5. PMTCT: Scale up rapid test for all infants at 18 months and rapid test after breastfeeding cessation. Scale up family index testing to reach children who constitute 80% of the ART unmet need.
6. Key Populations: improve linkage to 90% in COP19 and 95% by COP 20. Promote integrated service delivery with linkage to DSPs. Implement intensive case management to ensure 95% viral load suppression by COP20.
Other Government Policy or Programming Changes Needed

1. Strengthen provincial level engagement to ensure accountability of provinces to translate national-level client-centered policies per the Minimum Program Requirements down to the district and site level. 2. Local Civil Society Organizations must continue to independently monitor sites in collaboration with PEPFAR, GoSA and DSPs to advise on solutions to identified gaps.
Scale the Ambassador's Community Grants Program to increase support for CSO-led monitoring in the HIV response. 3. In support of efficiency and effectiveness of the PEPFAR program overall, there are opportunities presented with the dramatic increase in DREAMS, PrEP and other areas to begin to align agency strengths to improve maximum impact and reduce inefficiencies. For COP 2020, PEPFAR South Africa should use performance results and the increased funding in DREAMS, PrEP, and others areas to align agency strengths to improve maximum impact and reduce inefficiencies.

COP 2020 Technical Priorities

Client and Family Centered Treatment Services

COP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients, and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site- level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services. South Africa must ensure 100% "known HIV status" for biological children of TX_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

Community-led Monitoring

In COP 20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)

Groups to be prioritized for PrEP include those testing negative in index testing but remaining at increased risk of HIV acquisition by virtue of unprotected exposure to a PLHIV with unsuppressed viral load, key populations including sex workers, men who

have sex with men, transgender persons, people who use drugs, adolescent girls and young women, including pregnant and breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified serodiscordant couples. (Groups will be tailored to country context).

TB Preventive Treatment (TPT)

TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP20; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

DREAMS

DREAMS funding is allocated within your COP 2020 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2020 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP20 DREAMS implementation include: systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition, improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR), and accelerating PrEP uptake for AGYW.

PEPFAR South Africa is receiving a significant increase in new DREAMS funding which should be used for the following:

- **Interagency** expansion into new districts: The following 14 districts should receive new DREAMS funds for COP20. These districts have either an extremely or very high incidence (1.26-2.83%) and over 100,000 PLHIV, but have no DREAMS or Global Fund AGYW presence.

Country	DREAMS SNU	UNAIDS F15-24 Incidence Estimate	UNAIDS Incidence Classification	PLHIV (COP19 DataPack)
South Africa	kz Uthukela District Municipality	2.83	Extremely high	138,456
South Africa	kz Ugu District Municipality	2.67	Extremely high	132,564
South Africa	ec Alfred Nzo District Municipality	2.29	Extremely high	117,619
South Africa	fs Thabo Mofutsanyane District Municipality	2.17	Extremely high	129,715
South Africa	ec Chris Hani District Municipality	1.96	Very high	98,315
South Africa	ec Buffalo City Metropolitan Municipality	1.93	Very high	119,190
South Africa	fs Lejweleputswa District Municipality	1.80	Very high	101,741
South Africa	ec Amathole District Municipality	1.64	Very high	95,196
South Africa	nw Dr Kenneth Kaunda District Municipality	1.64	Very high	103,887
South Africa	mp Nkangala District Municipality	1.63	Very high	203,326
South Africa	lp Mopani District Municipality	1.62	Very high	146,589
South Africa	nw Ngaka Modiri Molema District Municipality	1.56	Very high	109,558
South Africa	gp Sedibeng District Municipality	1.53	Very high	125,223
South Africa	lp Capricorn District Municipality	1.26	Very high	127,890

  - Note: The geographic expansion mentioned here is limited to NEW DREAMS funds. Any expansion within the existing DREAMS envelope is subject to the criteria laid out in COP20 guidance (i.e., must have reached saturation, must have shown progress via WAD modeling data, or some

other data).

- STIs: South Africa is one of the countries in which we would like to conduct STI testing and treatment. $148,000 of your new DREAMS funds should be dedicated to STI testing and treatment. Further details on the number of AGYW that will likely need to be tested, the cost of testing and treatment for each type of STI will be provided, etc.
- PrEP: Significantly scale-up PrEP for AGYW in all DREAMS districts.
- Minimum Requirements for new funds: To receive additional funds, South Africa must present a strategy and a timeline at the COP meeting for the following:
    - Hire a dedicated DREAMS Coordinator and Deputy (100% LOE) within the PCO.
    - Hire a DREAMS ambassador for each province to support DREAMS coordination and oversight
    - Implement approved, evidence-based curricula in line with the current DREAMS Guidance
    - Ensure a fully operable layering database with unique IDs across IPs and SNUs
    - Ensure a full geographic footprint in all districts--in large urban areas focus on areas with highest need.
    - Address challenges and ensure DREAMS implementation in all districts with fidelity

OVC

To support the Minimum Program Requirement described above, in COP 20 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi- disciplinary care team and addressing key issues such as bi-directional referral protocols, case conferencing, shared confidentiality, and joint case identification. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

VMMC

Funds have been provided to conduct VMMC for males 15 years or older. The team is reminded of the revised guidance which allows surgical VMMC under the age of 15 only by the dorsal slit method and only for those who have attained Tanner stage 3 or higher of development and are able to provide full informed consent for the procedure. While Shang ring may be considered for those below age 15 regardless of Tanner stage, the same informed consent issues apply. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0, or complement Global Fund or other donors financing implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma, and can inform future HIV program planning. If the revised Stigma

Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 20, whether supported by PEPFAR or other resources.

COP 2020 Stakeholder Engagement (see section 2.5.3 of COP Guidance)

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP 2020 remains a requirement for all PEPFAR programs, and as such the COP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2020. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, GA where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Specific guidance for the 2020 meeting delegations have been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP/ROP 2020 development and finalization process. As in COP 2019, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP/ROP 2020 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment: If there is no adjustment to the COP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in

Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.

Orphans and Vulnerable Children (OVC): Countries must program to the full OVC amount from Part 1 of the planning across all funding sources. Your OVC requirement is made up of the HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.

HKID Requirement: South Africa's COP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your COP 2020 HKID requirement is derived based upon the approved COP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The COP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

*Gender Based Violence (GBV): OU's COP 2020 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2020** funding programmed to the GBV cross-cutting code. Your COP 2020 earmark is derived by using the final COP 2019 GBV earmark allocation as a baseline. The COP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.*

*Water: South Africa's COP 2020 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2020 funding** programmed to the water cross-cutting code. Your COP 2020 earmark is derived by using the final COP 2019 water earmark allocation as a baseline. The COP 2020 planned level of new FY 2020 funds for water can be above this amount; however, it cannot fall below it.*

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs.
*PEPFAR has set a 70% goal **by agency** by the end of FY20 and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential*

services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP/ROP 2019 submission.

COP/ROP 2020 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)
All agencies in South Africa should hold a 3 month pipeline at the end of COP 2020 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP2019 implementation (end of FY 2020) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP 2020, decreasing the new funding amount to stay within the planning level.